

# Patient Request for Health Information

**Patient Information (Please Print)**

First Name:	Middle Initial:	Last Name:
Name at Time of Treatment (if different than above):		
Date of Birth (MM/DD/YYYY):	Phone:	E-mail (optional):
Street Address:	City:	State:      Zip:

**What records do you want? (Check appropriate boxes below):**

Date(s) of Service: \_\_\_/\_\_\_/\_\_\_ through \_\_\_/\_\_\_/\_\_\_

- Discharge Summary   
  Emergency Room Records   
  Operative/Procedure Reports   
  Billing Records  
 Test Results (X-Rays, Lab/Pathology Results) Please specify: \_\_\_\_\_  
 Other (Immunization Records, Medication Lists) Please specify: \_\_\_\_\_

**How would you like your records delivered?**

- Paper  
      Home Delivery  
      In-Person Pickup  
 Electronic (Email, USB, CD, Portal, Other) Please specify: \_\_\_\_\_

**Where do you want the information sent? (Fill in boxes below):**

should provide my records to:    Self    Personal Representative (indicated below)

Recipient Name:	Recipient Phone:
Recipient Mailing Address:	Recipient Fax:
	Recipient E-mail (if applicable):

**Please print your name and sign below:**

<b>Name of Patient or Personal Representative (please print)</b>	<b>Relationship (please print)</b>
<b>Signature of Patient or Personal Representative</b>	<b>Date/Time</b>

**Please return completed form to:**

	E-mail:
	Fax:
	Questions?

*recognizes a patient's right under HIPAA to access copies of his/her health information.  
There may be charges associated with processing a request and producing requested records.*